Testicular Tumor with Axillary and Supraclavicular Mass –A Rare Case Report

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Abstract- We report a case of testicular tumor which is presented with axillary and supraclavicular mass, after confirmation of diagnosis bilateral orchiectomy followed by adjuvant chemotherapy with VIP regimen and radiotherapy to Para aortic region. Patient is asymptomatic now and on regular follow-up and completed 4 years of follow-up with no complications.

Index Terms- Testicular Tumor, Axillary Mass, Chemotherapy

I. INTRODUCTION

Supraclavicular lymph node metastasis from infradiaphragmatic malignancies generally indicates widespread disease that lost the chance of surgical treatment for cure, but testicular carcinoma represents an exception to this generalization.[1] Testicular carcinoma (seminomatous and nonseminomatous tumors) is the most common malignancy in men between 20-30 years of age. [2, 3] Cryptoorchidism, Klinefelter's syndrome and chromosomal abnormality in 1 and 12 are predisposing factors. Signs and symptoms are painless testicular mass, abdominal pain and mass, neck mass and gyanecomastia. Although the disease usually presents as a testicular mass or enlargement, abdominal, thoracic or cervical masses indicating metastatic disease may be noted during the follow-up. [1-3] Neck metastasis in the patients with testis cancer is an infrequent but, well established phenomenon and the incidence of neck metastasis in testicular carcinoma has been reported to be 4-5 %.[4-7] High inguinal orchidectomy is diagnostic as well as therapeutics procedure. Histopathologically it is divided mainly into seminomatous and nonseminomatous group. Management of testicular tumor depends upon stage and histopathology. In early stage seminomatous tumor either surveillance or radiotherapy or chemotherapy depending upon risk factors while in advanced stage and non seminomatous group chemotherapy is preferred treatment option. While in selected case retroperitoneal lymph node dissection (RPLND) or surveillance is optional. Testicular tumors are one of tumor which is considered as curable tumor.

II. CASE REPORT

30 years old gentleman presented in OPD with chief complained of swelling in left axilla since 5 months and swelling over left supraclavicular fossa since 2 months duration, no other significant complains, symptoms are progressive in nature. On examination his vitals was stable with intact higher mental functions. Local examinations of left axilla a 6×7 cm^2 single swelling with central ulceration and discharge present. Left supraclavicular fossa shows 3×4 cm^2 lymphadenopathy present, No other lymphadenopathy seen. Left testicular swelling was seen which non tender and loss of sensation. His other systems were normal.

His routine blood count, liver function tests, renal function tests and Chest X-ray PA view were within normal limits. USG abdomen and pelvis shows of multiple Para-aortic lymphadenopathies with largest size 3.4×4.2 cm^2 and rest things within normal limit. USG scrotal shows left testicular mass, suggestive of testicular tumor. Biopsy report done from axillary mass showed of metastatic carcinoma. Tumor marker AFP & B-HCG were significantly elevated. With this information high inguinal Orchidectomy was done under spinal anesthesia. Histopathology report showed mixed germ cell tumor. He was planned for chemotherapy using VIP regimen, in form of injection Ifosfamide 1.2gm/m^2, injection Cisplatin 20mg/m^2 and injection Etoposide 100mg/m^2 Day1 to Day5 repeated every three weekly. The course of chemotherapy was uneventful. After completion of 4 cycle of chemotherapy there were complete regression of axilla and supraclavicular mass but Para-aortic mass was partial regress, plan to continue two more cycle of chemotherapy followed by local radiotherapy at Para-aortic region. A dose of 36Gy in 18 fractions over 4weeks was delivered using two fields technique through Co-60 machine. After completion of treatment patient was advised for regular follow-up. In each follow-up complete physical examination and tumor marker every 3 monthly to be done. He completed 4years of follow-up.

III. DISCUSSION

Testicular tumor is one of the tumors, which is curable. It requires careful patient's evaluation, good planning and team approach in managements of patient.

Supraclavicular masses are the most common presenting features of malignant diseases with no detectable primaries, and they generally indicate widespread diseases which is not amenable to surgical resection for cure. Testicular carcinoma represents an exception to this generalization when metastasizes to the neck, as it usually spreads through lymphatic pathways. [1-3] initially, testicular carcinoma involves the retroperitoneal lymph nodes. The metastatic disease then spreads to the junction of internal jugular and subclavian veins via thoracic duct. From that location it may spread to cervical lymphatics. Testicular

carcinoma which metastasizes to the neck most commonly presents as a Virchow's node.[3] Therefore, a young man presenting with a supraclavicular mass, especially on the left side, should be suspected for testis cancer.

Testicular tumors are 96 % malignant and these are subdivided into seminomatous and nonseminomatous testicular carcinoma. Nonseminomatous testicular carcinomas are initially staged by physical examination, measurement of serologic tumor markers and computerized tomography scanning. [2, 5] Majority of the cases of nonseminomatous testicular carcinoma are diagnosed at early stage. An evidence of metastasis above the diaphragm, usually in the thorax, indicates advanced disease which is relatively rare and has poor prognosis. [2, 5] Nonseminomatous testicular carcinomas are treated by chemotherapy subsequent to orchiectomy. Aggressive chemotherapy can cause a histologic transformation leading the conversion of this lesion to a teratoma with scar and necrosis. Most likely, the chemotherapeutics selectively destroy the carcinomatous component leaving teratomatous remnants behind. In the majority of the cases, residual disease histologically consists of these teratomatous elements. Although teratoma is a nonmetastasizing form of testicular carcinoma, there is always some risk of eventual reversion of teratoma to its malignant counterpart. Therefore, surgical resection of the post-chemotherapy residual disease is recommended to control the disease and to avoid fatal complications due to progressive local growth. [4, 5]

Surgery (Orchidectomy) and chemotherapy were the mainstays of treatment, but radiotherapy is treatment of choice in early stage seminomatous tumors. Nowadays role of radiotherapy in testicular tumor is limited due to availability of chemotherapy which gives equal results to radiotherapy while on radiotherapy long term morbidity is high. Bleomycin, Etoposide and Cisplatinum is drug of choice for testicular tumor.

Nowadays, newer treatment modalities like 3D Conformal Radiotherapy and Intensity modulated radiation therapy (IMRT) dramatically reduce dose to non-target tissues like kidney, spinal cord, small bowel etc when radiotherapy is given to para-aortic region.

We reported a case which is unique in presentation because it presented with axilla mass which is very rare presentation of testicular tumour. (As shown: Figure No.1 & 2 showing mass in axilla & supraclavicular before chemotherapy and Figure No.3 & 4 showing mass in axilla & supraclavicular after chemotherapy).

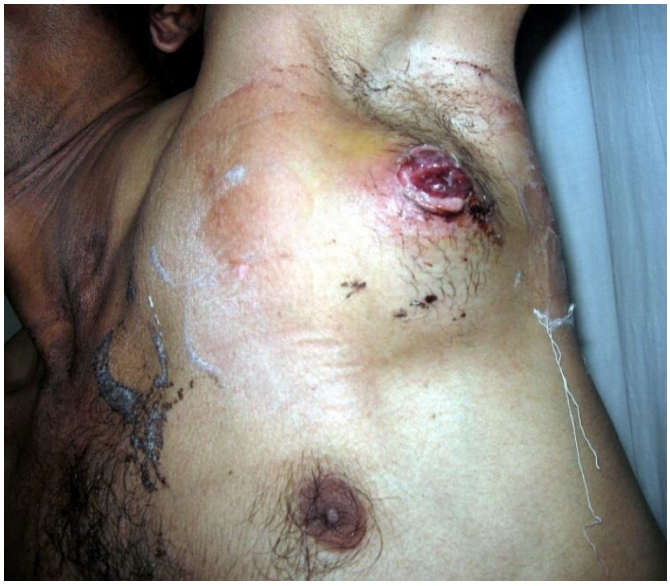

Figure 1

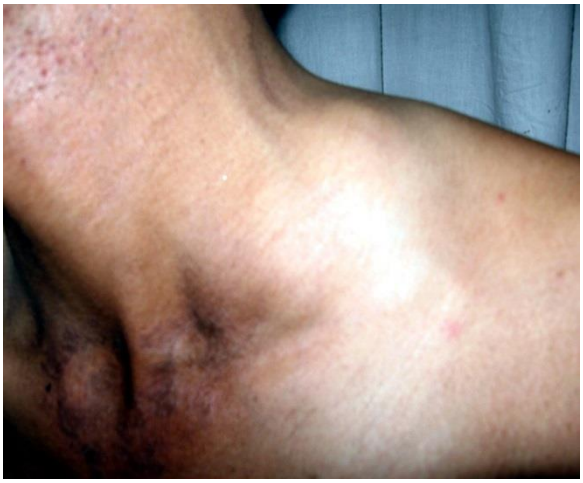

Figure 2

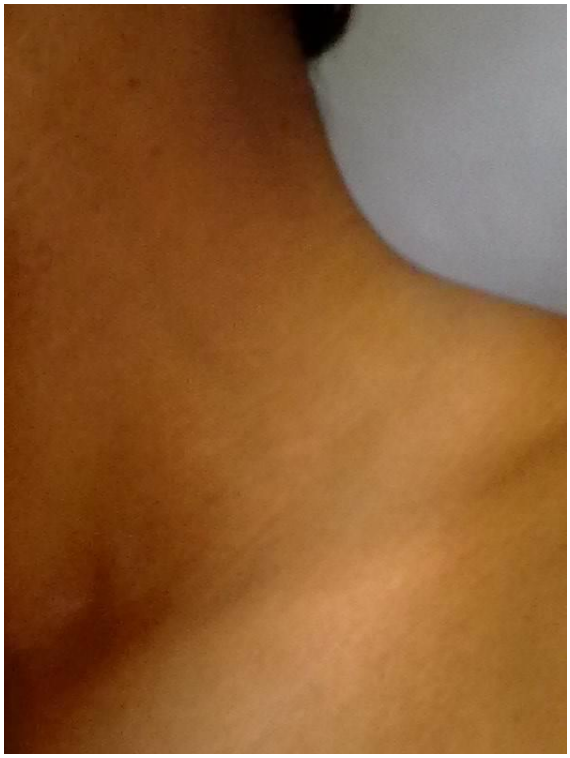

Figure 3

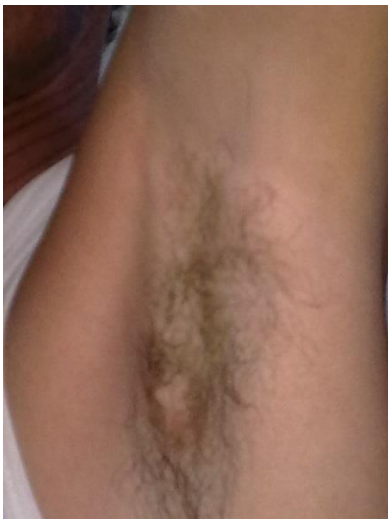

Figure 4

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